



**NOTICE OF EMPLOYEE TRANSFER TO ANOTHER STATE AGENCY**  
STATE FORM 50679 (R2 / 12-02)

**CARRIER:** The following employee has transferred to another agency. Please make the necessary changes in your membership records to reflect this change.

**AGENCY:** When you have an employee transfer out of your agency, complete each section, place a check mark in the appropriate spaces, and forward copies of this form to the carriers and to the new agency. Keep a copy for your agency's records. Please print for clarity.

**EMPLOYEE SECTION:**

Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

**AGENCY SECTION:**

Current Agency: \_\_\_\_\_

New Agency: \_\_\_\_\_

**PAYROLL SECTION:**

Date of last Payroll Check from current agency: \_\_\_\_\_

Date of first Payroll Check from new agency: \_\_\_\_\_

From:	<input type="checkbox"/> A-Payroll	To:	<input type="checkbox"/> A-Payroll
	<input type="checkbox"/> B-Payroll		<input type="checkbox"/> B-Payroll
	<input type="checkbox"/> Quasi/ Direct Bill		<input type="checkbox"/> Quasi/ Direct Bill

**COVERAGE SECTION:**

Health:  
☐ Anthem Traditional  
☐ Advantage  
☐ Anthem HMO  
☐ Arnett  
☐ Humana  
☐ M-Plan

Dental:  
☐ Traditional Dental  
☐ Dentacare  
  
Vision:  
☐ Spectera  
  
Taxesaver:  
☐ Pre-Tax  
☐ No Pre-Tax

Life:  
☐ Basic  
☐ Supplemental  
☐ Dependent  
  
Spending Account:  
☐ Medical  
☐ Dependent

\_\_\_\_\_/\_\_\_\_\_  
(Name/Title of person completing form)/ Phone # (Date)